Million Hearts Symposium: Reimbursing Care Coordination

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MARYLAND
DEPARTMENT OF HEALTH
& MENTAL HYGIENE

Overview of Reimbursement Opportunities for Care Coordination in MD

- Medicare Waiver
- SIM
- Community Health Workers Workgroup
- Medicaid Health Homes
- Million Hearts Grants
- MCO Care Coordination—Special Populations
- Transitional Care Management
- Medicare reimbursement

New Medicare Waiver

- Announced January 10, 2014
- Maryland will agree to permanently shift away from its current statutory waiver, which is based on Medicare payment per inpatient admission, in exchange for the new Innovation Center model based on Medicare per capita total hospital cost growth.
- This model will require Maryland to generate $330 million in Medicare savings over a five year performance period, measured by comparing Maryland's Medicare per capita total hospital cost growth to the national Medicare per capita total hospital cost growth.
- This model will require Maryland to limit its annual all-payer per capita total hospital cost growth to 3.58%, the 10-year compound annual growth rate in per capita gross state product.
- Maryland will shift virtually all of its hospital revenue over the five year performance period into global payment models.

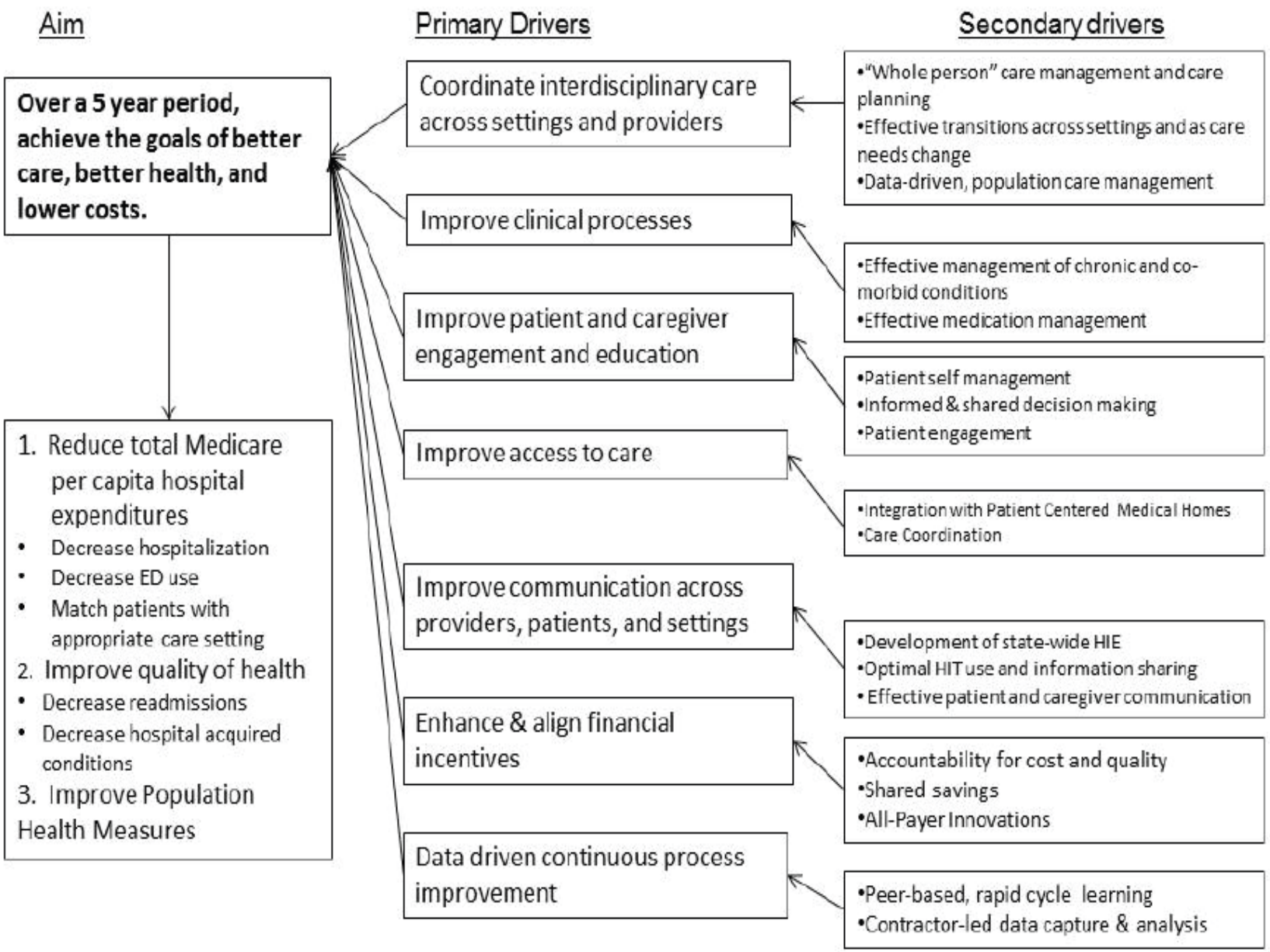
New Medicare Waiver

- Maryland will achieve a number of quality targets designed to promote better care, better health and lower costs. Under the model, the quality of care for Maryland residents, including Medicare, Medicaid, and CHIP beneficiaries will improve as measured by hospital quality and population health measures.
  - **Readmissions:** Maryland will commit to reducing its aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate in Maryland to the national Medicare 30-day unadjusted all-cause, all-site readmissions rate over five years.
  - **Hospital Acquired Conditions:** Maryland currently operates a program that measures 3M's 65 Potentially Preventable Conditions. Under this model, Maryland will achieve an annual aggregate reduction of 6.89% in the 65 PPCs over five years for a cumulative reduction of 30%.
  - **Population Health:** Maryland will submit an annual report demonstrating its performance along various population health measures.

New Medicare Waiver

- Aligns financial incentives across multiple payers
- Hospitals will be focused on care coordination
- Opportune time for partnerships to facilitate care upon hospital discharge, prevent re-admissions via management of chronic diseases

MARYLAND ALL-PAYER MODEL DRIVER DIAGRAM



DHMH revised model design proposal to CMMI

SIM Planning Grant: Medicaid ACO

- The Center for Medicare & Medicaid Innovation (CMMI) awarded Maryland $2.5 million in designing and further refining Maryland's State Health Care Innovation Plans.
- With $1.5 million of this Model Design funding, Maryland will create a Medicaid Accountable Care Organization (ACO) to coordinate the care of individuals who are eligible for both Medicaid and Medicare ("dual eligibles").
- The successful implementation of a Medicaid ACO will necessitate the creation of appropriate infrastructure, including the development of a clinical care management tool and the leveraging of EHRs to track and report on outcomes. Eventually, this infrastructure will be integrated into CRISP.
- This initiative will be implemented first in Baltimore City with the goal of eventually expanding the program to cover dual eligibles statewide.
- Improving care coordination for this high-cost population has the potential to result in significant reductions in the total cost of care.

Community Health Workers

- HB 856 mandated the creation of a stakeholder workgroup to study and make recommendations regarding the Workforce Development for Community Health Workers in MD; jointly led by DHMH and MIA

- The workgroup has been tasked to study and make recommendations regarding:
  - The training and credentialing required for community health workers to be certified as nonclinical health care providers, and
  - Reimbursement and payment policies for community health workers through the Maryland Medical Assistance Program and private insurers

- Report due June 2015

Health Homes

- Intended to improve health outcomes for individuals with chronic conditions by providing patients with an enhanced level of care management and care coordination.

- Section 2703 of the PPACA of 2010, "State Option to Provide Health Homes for Enrollees with Chronic Conditions," created the option for state Medicaid programs to establish Health Homes

- Provide an integrated model of care that coordinate primary, acute, behavioral health, and long-term services and supports for Medicaid enrollees

- Maryland Office of Health Services submitted a Medicaid state plan amendment (SPA) that was approved by CMS) and became effective October 1, 2013

Health Homes

- Targets populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services from providers from whom they regularly receive care.

- Focused on Medicaid enrollees with either a serious and persistent mental illness (SPMI), or an opioid SUD and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use.

- This includes children with serious emotional disability (SED) as well as the SPMI

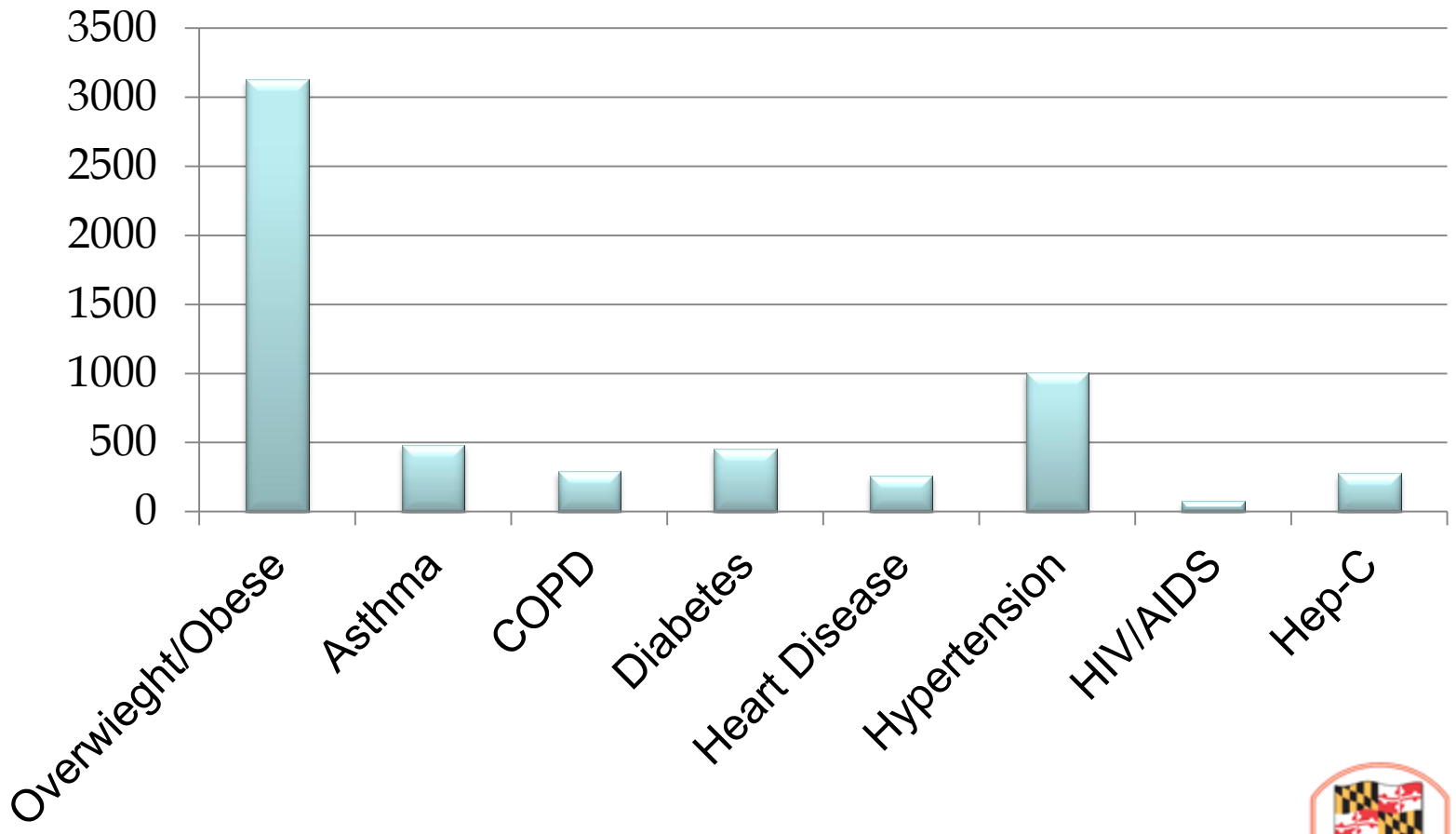
Health Homes

- Psychiatric Rehab Program, Mobile Treatment, and Opioid Treatment Program providers
- Accreditation & staffing requirements
- Min. of 2 services per month
- Monthly payment rate
- Core Services include:
  - ➢Comprehensive Care Management
  - ➢Comprehensive Transitional Care
  - ➢ Care Coordination
  - ➢Individual and Family Support
  - ➢Health Promotion
  - ➢Referral to Community and Social Support

Health Homes: Current Stats

- Health Home sites enrolled: 70
- Participants Enrolled: ~4,800
- Claims paid: ~$300,000/month
- Counties w/ a Health Home: 21 of 24

Health Homes: Reported Somatic Conditions



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Health Homes

DHMH.HealthHomes@Maryland.gov

http://dhmh.maryland.gov/bhd/SitePages/Health%20Homes.aspx

Million Hearts Initiative: MCO Grants

- December 2014: Medicaid Planning Administration, in partnership with the DHMH Center for Chronic Disease Prevention and Control, issued two new grant opportunities intended to provide resources to Maryland HealthChoice MCOs

- Grants aimed at enhancing care management focused on:
  - Hypertension Identification, Control and Improvement
  - Diabetes Prevention and Control
  - Leveraging existing Million Hearts efforts

Million Hearts Initiative: MCO Grant Awards

- $25,000 to Riverside Health Of Maryland for:
  - Focus on Diabetes Prevention and Control in Maryland's HealthChoice Program
- $25,000 to Amerigroup Community Care for:
  - Amerigroup Shared Medical Appointments for Hypertensive Members: A Collaborative Model: Amerigroup, Hospitals, and Community
- $25,000 to Amerigroup Community Care for:
  - Amerigroup Shared Medical Appointments for Diabetic Members: A Collaborative Model: Amerigroup, Primary Care Providers, and Community

MCO Care Coordination of Special Needs Population

1. children with special health care needs;
2. individuals with a physical disability;
3. individuals with a developmental disability;
4. pregnant and postpartum women;
5. individuals who are homeless;
6. individuals with HIV/AIDS;
7. individuals with a need for substance abuse treatment;
8. children under state supervision.

The general provisions for special needs populations include:

- ensuring that Pediatric and adult Primary Care Providers (PCPs), and specialists are clinically qualified to provide or arrange for specialized services;
- developing referral protocols that demonstrate the conditions under which PCPs will make the arrangements for referrals to specialty care networks;
- coordinating case management as part of enrollee's comprehensive plan of care;
- identifying a special needs coordinator as a point of contact for health services information and referral;
- making efforts to contact and educate enrollees who fail to appear for appointments or who have been non-compliant with a regimen of care; and
- after documented unsuccessful outreach efforts, the MCOs must refer the case of the non-compliant enrollee to the local health department for assistance in returning the enrollee to care.

Transitional Care Management

- Transitional care management (TCM) services are designed to prevent readmissions
- Within 30 days after a beneficiary leaves a hospital, skilled nursing facility, or community mental health center partial hospitalization program
- Each requires contacting the patient within 2 business days; a face-to-face visit within 14 or 7 calendar days; moderate or highly complex medical decision-making; and detailed care coordination activities.
- Reimbursement of CPT codes 99495, 99496
- One provider – usually a primary care provider, but a specialist, when appropriate — can bill the service, per patient per discharge.

Medicare Reimbursement

- Complex chronic care management codes below took effect Jan. 1, 2013: 99487, 99488, 99489
- Based on time with and without face-to-face visit
- For patient centered management and support services to individuals at home, or in a domiciliary, rest home, or assisted living facility
- Require a care plan that is directed by the physician or qualified health care professional and usually implemented by clinical staff
- Coordinate care being given by multiple disciplines or community service organizations

Medicare Reimbursement

- Effective January 1 , 2015, Chronic Care Management (CCM): the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions.
- In addition to office visits and other face-to face encounters (billed separately), these services include communication with the patient and other treating providers for care coordination (both electronically & by phone), medication management, and being accessible 24 hours a day to patients and any care providers (clinical staff)
- The creation and revision of electronic care plans is also a key component of CCM.
- CPT code 99490 – 2015 average reimbursement is $42.60 adjusted based on geography.
- The practice must have the patient's written consent in order to bill for CCM services
- Only one clinician can furnish and be paid for CCM services during a calendar month

Questions:

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